



2017 Williamson County Medical Coverage

Medical Plan Enrollment and Change Form



Employee Name _____ SSN# _____ Employee Date of Birth _____

Address _____ City _____ State _____ Zip _____

Best Contact Number () _____ E-mail _____

Is your spouse a Board of Education or County Government Employee? Yes _____ No _____ If yes, name of your Spouse _____

Do you or your dependents have other coverage? Yes _____ No _____ If yes, please provide a copy of insurance card for any participants that have other coverage available at time of enrollment.

This form is only to be used when making changes due to a qualifying event

Life Changing Event Date _____

Type of Life Changing Event: Add Dependent (s) or Terminate Dependent(s)

Birth/Adoption Marriage Divorce Death
Loss of Coverage Gained Coverage Court Order Other _____

Enrollment Due to a life changing event requires proof validating the event

ENROLLMENT ELECTION (check one)

*Option 1 Deductible Plan w/ Health Savings Account

_____ Individual Enrollment _____ Employee + 1 Enrollment _____ Family Enrollment

By choosing Option 1, a Health Savings Account will be established for you through HSABank. Once your enrollment into the Deductible Plan w/Health Savings Account is complete the bank account will automatically be set up for you.

Indicate the annual amount you would like to have withheld from your salary and placed into your H.S.A. account for eligible health care expenses. Your 2017 election may be \$0 to \$3,400 for individual coverage or \$0 to \$6,750 for Employee +1 or Family coverage.

ANNUAL Amount elected: \$ _____

Annual amount elected will be divided by the number of pay periods remaining in the plan year (Jan 1 – Dec 31) by the benefits department.

*Option 2 Deductible Medical Plan

_____ Individual Enrollment _____ Employee + 1 Enrollment _____ Family Enrollment

* I decline Medical Coverage _____

LIST ALL FAMILY MEMBERS TO BE ENROLLED OR TERMINATED

First, M.I., Last Name	Sex	Enrollment Election	Social Security Number	Date of Birth	Does Member have other Coverage?
Spouse*	M	Add	- -	/ /	Yes
	F	Term			No
Child**	M	Add	- -	/ /	Yes
	F	Term			No
Child**	M	Add	- -	/ /	Yes
	F	Term			No
Child**	M	Add	- -	/ /	Yes
	F	Term			No
Child**	M	Add	- -	/ /	Yes
	F	Term			No

Enrollment of a spouse:** Spousal form must accompany this enrollment form. *Enrollment of a child:** Copy of child's birth certificate must accompany this enrollment form.

By signing below, I agree to all terms and conditions of enrolling in and continued enrollment in the Williamson County Medical program, as such exist on the date of my enrollment as reflected below, and as such may change from time to time, with or without notice to me. I further represent and warrant that all information given by me is accurate, current and complete to the best of my knowledge. I agree to allow the Williamson County Benefits Department to have the appropriate deductions taken from my paycheck according to my above enrollment options.

Employee Signature: _____ Date: _____